Title: Nurse Managed Patient Focused Assessment and Care: A Grounded Theory of Qualified Nurses in Acute and Critical Care Settings Assessing the Mental Capacity of Adult Patients

Abstract:

Aims: To explore processes used by qualified nurses in assessing mental capacity of acutely and critically ill hospitalised adult patients.

Background: Mental capacity is the ability to understand, reason, and make decisions. Acute and critical illness may impact upon the decision making abilities of hospitalised adult patients but little is known about how qualified nurses across a range of acute settings assess the capacity of such patients in their care

Design: A qualitative grounded theory approach informed by the Corbin and Strauss (2008) methodological pathway

Methods: Data were collected through digitally recorded, semi-structured interviews to explore assessment of capacity processes used by 13 registered nurses employed in acute and critical care environments in a district general hospital in South-Wales, UK. Data were analysed using iterative constant comparative processes leading to a core category and grounded theory. The study is presented in accordance with the COREQ checklist.

Results: Informal, intuitive, holistic nurse-led processes were used to assess the mental capacity of patients which combined processes for the assessment of their physiological and mental capacity status, recognising the need to support their rights, dignity and autonomy. The assessment of mental capacity was not a lone process but one that contributed to a cyclical process in which multi-professional assessment was necessary and ongoing, and in which qualified nurses had a co-ordinating role. This led to the development of the theory, Nurse Managed Patient Focused Assessment and Care.

Conclusion: This theory provides a framework to explain processes and strategies used by qualified nurses in assessing mental capacity of, and caring for, adult patients with acute and/or critical illness.

Relevance to clinical practice: This framework may inform related clinical practice and can serve as a basis of an assessment tool in what has been identified as a fundamental role of the qualified nurse.

Key words: Nursing, assessment, mental capacity, acute/critical care, grounded theory

Impact Statement

What does this paper contribute to the wider global community:

- **Assessing the mental capacity of acutely and critically ill adult, hospitalised patients is identified as a fundamental role of the qualified nurse**
- **The assessment of mental capacity, in this context, is not a lone process but is a key component of a dynamic, ongoing and responsive holistic assessment process, which is co-ordinated by nurses and subsequently requires multi-disciplinary approach**
- **The theory of Nurse Managed Patient Focused Assessment and Care provides a framework for understanding processes and strategies used by qualified nurses in assessing mental capacity of adult patients across acute and critical care settings**

1. Introduction

Mental capacity is central to concepts of autonomy and self-determination. It is the ability to use cognitive processes to understand, reason and to exercise choice by making decisions and enables freedom of expression that supports the notion of being an individual. Rights and freedoms are dependent on having the capacity to represent self and the ability to use information to inform decision making processes. In the UK, for an adult, a person over sixteen years, the law normally will not recognise consent to or refusal of healthcare treatment unless it is made with capacity (Richardson, 2010; Jones, 2016). Capacity therefore performs a crucial role in setting the threshold for the legal protection of decisions and the right to make decisions.

Acutely or critically ill adult patients needing hospital-based healthcare interventions may be required to make decisions that range from routine to life-saving or life-changing. Therefore having sufficient understanding and decision-making abilities are essential. The expression and articulation of capacity has its challenges. Many factors may impact upon a person being able to provide healthcare practitioners with evidence of capacity. These may include being suddenly admitted to hospital in an ill and frightened state with serious, sometimes life threatening illnesses, feeling a sense of panic and loss of control, being disorientated or confused, experiencing pain and discomfort or suffering from the effects of medication (Brazier & Cave, 2016). The quality and efficacy of assessment processes will depend on the skills of the individual practitioner and/or the healthcare team. In the UK,

assessing and concluding that a patient has reduced capacity or is without capacity will give the healthcare team the legal authority to assess best interests and provide care and treatment under this justification (Jones, 2016).

2. Background

Qualified nurses hold a unique position in multi-professional contexts. They are the only health professional group to provide a continuous, twenty four hour clinical service to patients which gives them a unique level of knowledge, exposure and proximity to patients and patient-specific detail. By the very nature of such exposure, qualified nurses may also have closer working relationships with relatives and carers. Qualified nurses therefore have a key role in making assessments that inform appropriate referrals to other members of the multi-professional team. This means that they often initiate assessments of capacity due to their ever-present status (Traynor et al., 2010). The assessment of capacity is a starting point and influential in the ways that nurses involve patients in their care and the results of assessments determine the extent to which the decision making of patients is facilitated. Assessment processes that determine capacity are therefore key, not only to establish a legal threshold for care and treatment, but also as a basis to facilitate patient involvement, choice and freedom of expression. Furthermore, qualified nurses may be confronted by patients whose condition may rapidly deteriorate. They are required to make decisions about the well-being, if not survival, of patients and often with little prior knowledge of them. The first time nurses meet patients is often when capacity is unstable or absent (McGlade et al., 2011).

The clinical landscape has an increasingly sophisticated legal context, informed by the enactment of primary legislation, such as the Human Rights Act, 1998 and the Mental Capacity Act, 2005. Both focus on the primacy of the rights of a person and both enforce autonomy, self-determination and choice as fundamental concepts. The Mental Capacity Act came into force in 2007, brings existing case law under statutory influence and provides a framework to facilitate the protection of those who lack the necessary mental capacity to make their own decisions (Brazier & Cave, 2016; Jones, 2016). Themes of upholding human rights and freedoms currently receive closer scrutiny than ever (Emmett et al., 2013) at a time when patient demands on acute and critical front-line healthcare services are unprecedented.

This is an area of nursing practice in which there is little existing evidence of directly related research, in particular regarding the specific mechanisms that qualified nurses use in assessing the mental capacity of patients with acute, critical and complex health needs in hospital settings where timeframes for employing healthcare interventions are often crucial. Supporting patients to make decisions are key legal, professional and practice imperatives and there are increasing expectations that nurses understand their role in making sound assessments of mental capacity to facilitate effective, person centred care. Operational processes to manage assessments are included across nursing curricular, both undergraduate and post graduate. However, education provision may not facilitate confidence in making sound assessments of capacity status or emphasise an appreciation that assessing capacity is a key element of the role of the nurse in supporting patients to make decisions in time limited environments. This suggests that further research is needed in this area.

The concept of mental capacity and the complexity of its definition are recognised (Patchet et al., 2007; Steis & Flick, 2008; Lamont et al., 2013). The common law test of capacity is also a well established concept since the enactment of the Mental Capacity Act 2005. This requires the assessment of understanding, retention of information and ability to use information to make and communicate decisions (Jones, 2016). The focus here is on decision making abilities, which are predicated upon abilities to understand and appreciate the significance of information to inform decision making processes (Jones 2016). Pre-dating the Mental Capacity Act (2005), assessment tools and interview guides for evaluating capacity have been in existence for some time and have been utilised by clinicians. These mainly originate from the USA and focus on patients with acute confusion, the elderly and/or those with mental health problems (Gunn et al., 1999; Moye et al., 2006; Okai et al., 2007; Brown et al., 2013; Elzakkers et al., 2018).

Several studies have noted that physical illness has a significant impact upon capacity and ability to make decisions. These have explored a lack of capacity in groups of patients with stable or chronic medical or surgical conditions (Appelbaum & Grisso, 1997; Smithline et al., 1999; Moser et al., 2002; Casarett et al., 2003; Raymont et al., 2004; Palmer et al., 2005; Appelbaum, 2007; Owen, 2009; Burton et al., 2012). Impairment of capacity in groups such as acutely ill patients has been less extensively studied, but it is recognised they contribute

to a large population in which reduced capacity can be anticipated (Raymont et al., 2004; Jacob et al., 2005; Lepping, 2011). None of these studies, however, focus upon the role, function and strategies of qualified nurses in assessing the mental capacity of patients in their care and how this may impact upon the ways patients are managed.

3. Methods

3.1 Design

A qualitative grounded theory approach, informed by the methodological pathway of Corbin and Strauss (2008) was used to explore processes and strategies used by qualified nurses in assessing the mental capacity of acutely and critically ill hospitalised adult patients. The flexibility of grounded theory methods were regarded as suitable for this study as was the structure of the coding paradigm of Corbin and Strauss (2008) to facilitate depth of analysis to realise the aims of this study. The study is presented in accordance with the COREQ checklist, see supplementary file 1.

3.2 Data Collection

A purposive sample of thirteen qualified nurses, representing Agenda for Change Bands 5 to 7 (ranging from staff nurse to sister/charge nurse and advanced practitioner levels), were recruited via a clinical gatekeeper/clinical nurse, from acute and critical environments in a large district general hospital in South East Wales, UK, providing a full range of emergency, intensive and acute care services across specialised departments, units and wards. Data were collected (by first author) using face-to-face semi-structured interviews. These were chosen as they are the method of choice of data collection in grounded theory research (Birks & Mills, 2011; Mills et al., 2014). Interviews provide open-ended in-depth exploration of a research area and were favoured for this study due to an anticipated complexity of assessment processes to which participants may allude. The lack of specific empirical evidence regarding capacity assessment processes used by qualified nurses indicated a need for a method of data collection that would enable participants to articulate assessment and intervention processes they employed. While participant observations were initially considered as an additional method of data collection, it was subsequently felt that attempting to observe nurses assessing capacity of acutely ill patients in time limited situations would be unfeasible, unethical and also, due to the potential Hawthorne effect,

methodologically problematic. It was concluded that there may be a need to facilitate reflective discussion during interviews, to provide participants with the opportunity to reflect and analyse what they did to assess capacity status of patients in their care, therefore interviews were chosen as the most appropriate method of data collection.

Interviews were conducted over a period of fifteen months at which point concepts and categories were saturated with data. Each lasted approximately 50 to 60 minutes and were audio-recorded and transcribed verbatim which provided a comprehensive written record and allowed for immersion in data. Field notes were also compiled during and immediately after each interview to record observations, impressions and thoughts. This enabled an organised approach and reduced the potential for being overwhelmed with data. Also, after each interview the schedule for the next was reviewed and, if appropriate, modified according to concepts and nascent categories that emerged from the previous interview. This allowed an approach which was consistent with grounded theory methods whereby data collection and analysis occur simultaneously (Charmaz, 2014).

3.3 Data Analysis

Constant comparative methods, a key aspect of grounded theory analysis, were used to collect and analyse data simultaneously (Corbin & Strauss, 2008; Urquhart, 2013). Concepts were identified from each interview transcript which formed the basis of open codes. These represented and contained processes of assessment and personal, professional, environmental and contextual factors that informed these processes. They also represented the role of the nurse and others in capacity assessment processes and in the care and management of patients during and after conclusions of capacity status were made. As more data were collected, open codes were analysed into groups where common ground could be identified. Thematic analyses were undertaken of these which resulted in the formation of nascent categories. These were further analysed as more data were collected using processes of axial coding with the application of the organisational scheme, or paradigm, recommended by Corbin and Strauss (2008). The paradigm model was applied to categories and their core phenomena to assist further analysis which highlighted that categories were closely related. The paradigm model was also applied to subcategories which had been identified during axial coding. This reaffirmed the fit of subcategories to

categories and also that axial coding had facilitated the identification of patterns and relationships between these. A theoretical paradigm model of the relationships between categories was constructed to assist in establishing a story or the main event in data. At this point the advice of Corbin and Strauss (2008) was revisited regarding a core category which has the power to explain what is at the centre the research. The core category was labelled as, "Nurse Managed Patient Focussed Assessment and Care". This represented core themes of the research and to which all categories related. Corbin and Strauss (2008) assert that theoretical integration means choosing a core category then telling the story around it using other categories identified during the research. Integrative, theoretical memos are regarded as a useful tool and can assist the researcher to identify the explanatory power of the core category, thus leading to the development of theory (Corbin and Strauss 2008). Therefore an integrated memo was used to confirm fit of the core category, and also confirmed the theoretical explanation of the processes employed by participants when they assessed capacity status. Further analyses and theoretical saturation of categories and subcategories resulted in the development of the theory, Nurse Managed Patient Focused Assessment and Care.

3.4 Rigour

The need to emphasise the importance of attention to quality in grounded theory studies is highlighted as is the need to ensure rigour and credibility (Corbin & Strauss, 2008; Birks & Mills, 2011). Validity must focus on research findings which are believable and trustworthy (Corbin & Strauss, 2008) and which have been developed through open processes of discovery (Thomas & Magilvy, 2011). To ensure rigour, validation by experts and participants were used for this study. Processes of supervision by the supervisory team and additional, external experts occurred on several levels. All aspects of data collection, analysis and coding processes leading to the identification of a core category and emerging theory were critically discussed, reviewed and refined with the supervision team. Additional expertise was called upon and experts were invited to form an Advisory Board. This consisted of a Critical Care Nurse Consultant and a Professor of Psychology, who is an expert in grounded theory research, both having in-depth of knowledge and experience and an active role in ensuring rigour of the research process and findings. The Advisory Board met regularly and assisted in the development, refinement and analysis of findings of the

research. Participant validation involves returning to participants and asking them to review transcripts, and/or to validate processes of data analysis to confirm or reject the interpretations of the researcher (Birks and Mills 2016). Around half of the participants in this study responded to an invitation to attend a focus group event, to help validate the core category of this study and to critically comment on a visual representation of process of assessment and emerging theory which had been identified in data. They therefore validated processes of data analysis and supported further critical refinement of theme and theory development.

In addition, the use of a reflexive approach was identified as a key strategy to promote quality and to evidence accountability in the use of essential grounded theory methods (Birks & Mills, 2011). Reflexivity is defined as an active process of systematically and logically developing insight into the work of the researcher to guide future actions through critical analysis of all aspects of the research experience (Birks and Mills 2011). A reflexive approach was employed on a number of levels using a journal as the main vehicle to record insights, field notes, memos, interpretations of data, thematic analyses and processes leading to the identification of a core category and development of the grounded theory. Thus, evidence trails were made of methodological decision making, methods used and processes of analyses throughout this study.

3.5 Ethical considerations

Ethical approval for this study was granted by a relevant Faculty Research Ethics Committees. Approval from an NHS Research Ethics Committee was not required at the time when the study was conducted as participants were qualified staff rather than patients. Voluntary informed consent was obtained from participants and identification codes were used to protect anonymity and confidentiality.

4. Results

Nurse Managed Patient Focused Assessment and Care explains how qualified nurses assess the mental capacity of acutely and critically ill patients. Five categories were identified as having explanatory power:

- Factors informing nurse-led assessment

- Nurse-Led Assessment
- Influence of the role of others
- Impact of clinical setting
- Caring role of the nurse

4.1 Factors Informing Nurse-Led Assessment

The presentation of patients in acute and critical clinical environments resulted in participants responding by using and applying knowledge which informed the need to investigate the capacity status of patients in more depth. Definitions of capacity were used which demonstrated understanding legal definitions, such as decision making abilities with required levels of understanding, retention of information and communication abilities (Mental Capacity Act, 2005). Informal definitions of capacity were also used such as being "normal" which was linked to awareness of situation, having ability to hold a conversation and display appropriate behaviour and understanding.

Participants recognised the use of personalised, informal assessment processes. These were enhanced by having what were described as "gut feelings" about patients and were commonly described as "something not quite right". This was a label that re-occurred frequently, as participants discussed their strategies for patient assessment:

> *"You're talking to patients and can see that something is not quite right. You have a gut instinct, hang on, this patient does not seem to be taking in what I am saying. I think it's a gut feeling sometimes as a practitioner when a patient does not feel comfortable. I think it's quite difficult to put into words. As a practitioner, I think it is something that can be gained from experience. You get a gut feeling when a patient is not with it, sometimes they are not well and their observations are not showing much. You think something is not quite right here, it's a sort of a nagging feeling. I suppose It's patients behaviour and being aware of body language with patients who are receiving information. I think you need to be thinking that you are continually assessing your patient and analysing their behaviour. I think that all practitioners do it when they are watching and receiving information".* **(F04).**

The articulation of "gut feelings" indicated that participants were utilising processes of continual information gathering and initial assessment, the results of which were expressed as "gut feelings". An analogy was used of putting pieces together to inform judgements about patients. Participants therefore suggested there was a need to get a full picture of the presentation of patients, using prior exposure experience, thus laying a detailed foundation upon which to base an assessment of capacity. Also the speed of assimilating this information led to conclusions of experiencing "gut feelings". This indicated that participants were assessing rapidly due to the nature of their clinical environments and the acute needs of patients.

4.2 Nurse-Led Assessment

Assessment processes commenced with a presumption of capacity, reflecting the requirements of the Mental Capacity Act 2005. A recognition that capacity status required further investigation resulted in the application of informal nurse-led assessment processes despite knowledge of pre-defined assessment of capacity criteria such as the Mini Mental Test (Folstein et al., 1975). Informal processes reflected the legal requirements of assessing understanding, retention, decision making and communication abilities :

> *"Nurses level for capacity assessment is about assessing if the patient is alert and orientated. You assess cognitive status and are they orientated to time, place and person. You have to get underneath this and you are looking to see if they understand and can remember things back to you, this is where you see what they communicate like, are they making sense? You are setting the patient up to see if they can make decisions. I suppose this is the same as the Mental Capacity Act which came in a few years ago"* **(F13).**

In discussing informal nursing assessment strategies, participants described a functional approach to capacity assessment, the approach taken in the Mental Capacity Act 2005, as they understood that capacity is decision-specific, related to the ability of a patient to make decisions at a particular time and allowing for temporary loss of capacity or fluctuating capacity. This approach was regarded as appropriate and effective when caring for patients with unstable diagnoses during which capacity may fluctuate or be lost.

The proximity of participants to patients enhanced the informal nature of assessment processes used. Time spent with patients in the provision of care and management interventions provided opportunities to assess capacity unobtrusively or to assess at differing times to confirm capacity status. Also the advantages of participants being able to assess patients continually due to their proximity to patients on a 24 hours basis were recognised. This allowed gathering and assimilating detailed information regarding the capacity status of patients and assessing in a manner that was not obvious to patients. This was regarded as giving a realistic view of the capacity status of patients, many of whom were ill and frightened.

Visual assessments were considered fundamental to nurse-led assessments of capacity status. The appearance of patients was often a stimulus to investigate further. This was an initial, often quick visual assessment but one which sometimes resulted in immediate follow-up. Participants alluded to walking past patients, observing from a distance whilst carrying out day-to-day nursing activities as a matter of coincidence, and being alerted to "something not quite right". This resulted in emphasis given to the quality of eye contact when interacting with patients. Interpersonal skills were used in making assessments of the responses of patients as indicators of capacity were investigated. These included understanding the need to engage with patients and also the need to interpret the ways in which patients presented. This was described as "looking at patients to see if there were glimmers of capacity", namely, the presentation of patients evidenced appropriate non-verbal communication such as listening, and appearing to follow conversations.

Assessing patient appearance was broadened to encompass their physical condition with an acknowledgement that rapid physical assessments also revealed capacity status. Therefore responses were made to physical and capacity status simultaneously, regardless of what had actually prompted an approach the patient:

> *"I notice if the patient changes colour even if observations are fine. I had one patient, there was something about him that I can't put into words, he looked grey and there was something not quite right about him, nothing that I could put my finger on, but his colour had changed. We treated this as an urgent situation but there was nothing physical that would explain this. At the time I thought that his behaviour was odd. I*

realised that he was confused and his capacity levels had dipped. Later that night he had a major cardiac event" **(F08).**

For patients who appeared to have either fluctuating, diminished or no capacity, assessments continued to help gather information to confirm and justify initial conclusions. Here processes of elimination were described and assessments proceeded until physical causes for the manner in which patients presented had been excluded. Markers were used such as pyrexia, the presence of pain, altered levels of consciousness, under the influence of drugs or looking for other trigger mechanisms to explain altered or absent capacity. In addition, deterioration in levels of capacity resulted in vigilance regarding the physical status of patients with recognition that physical instability was closely linked to levels of capacity

The proximity of participants to patients and working as a nursing team enabled the pooling of information about the capacity status of patients and also provided opportunities to validate the results of nursing assessments. This provided mutual support amongst the nursing team and also enabled opportunities to obtain second opinions regarding the accuracy of nursing judgements and assessments of capacity.

A team approach was extended to assessment by the multi-professional team**,** in particular relationships with doctors in ongoing assessment processes. Nursing judgements and assessments of capacity status were considered significant in influencing multi-professional team conclusions about the capacity of patients. A circular process was described which was nurse initiated and returned to nurses after the input of doctors. This was articulated as a dynamic assessment of capacity cycle:

"Its nurses who call the doctors when it's identified there are problems with capacity. We flag up the problems and get them to see the patient. We highlight the problem, they may do a Mini Mental but a great deal of the time the doctors go with the nurses. So nurses identify the problem and they [*the doctors] go in keeping with the nursing assessment. Nurses spend most of their time with the patient, the doctors tend to listen to us because of this. If for example we refer to a consultant, this consultant comes back to the nursing staff to ask what is going on. It's the same thing, it's a circular thing. The nursing staff identify the issues, the team [the doctors] do a referral to a consultant, then the nurse gives the consultant all the information they have on a patient. Nurses start it off, it goes round and comes back to nurses. I*

suppose, what I am saying is that by nurses identifying a problem they are sort of assessing capacity and the doctors tend to go with this as nurses have the biggest knowledge about the patients" **(F10).**

4.3 Influence of the Role of Others

Relatives and carers supported participants in gathering intelligence regarding establishing baselines for patients in the need to ascertain patient-specific definitions of "normal". Family and carers had an on-going role in processes of assessment and provided valuable information in supplying insights into definitions of what constituted "normal" for patients. Challenging timeframes and the unstable and unpredictable nature of the physical status of patients often resulted in participants gathering and assimilating information rapidly in ways that were cognisant of the physiological priorities of patients. This often resulted in assessments of the reactions of family members or carers such as concern and distress if patients displayed signs of confusion or out of character behaviour. This provided relevant information which was subsequently used in the assessment process.

Members of the multi-professional team were also recognised as being able to contribute in clarifying the background and prior history of patients, in supporting nursing assessment of capacity status and in taking this further. The doctor was considered significant in a multi-professional team context. When caring for acutely ill patients, participants discussed working with doctors at the point of administering clinical interventions in time limited situations and described working as members of multi-professional teams, at the same time influencing team assessments of the capacity status of patients by making nurse-focused contributions. Differences in the role of the nurse and doctor in making capacity assessments were highlighted and the ways in which patients responded to both professional groups. Nursing assessments were considered informal, but essential, with nurses then contacting doctors to formalise and continue assessment processes:

"When I'm working with a patient who is on a trolley I am looking to see if the patient can hold eye contact, or I am thinking things like, yes he is here with me and there is listening going on. It's the way the patient responds to me. The things that I am saying across the trolley to the doctors is not the patient has got capacity, or he's consented to this, it's more I've got a pulse and an output. Some patients cannot communicate but you have engaged with their face, I will have done this and not the

doctors, I may have done this before the doctors got there. So it would be me thinking about capacity and patients dignity more than doctors. I would then tell them that capacity is there or not there and they factor this in. This is what the nurse does in these situations and doctors know that. They tend to accept our opinions about patients"
(F03).

The majority of contact with doctors involved referrals made to them by participants after informal nurse-led assessments had taken place. It was regarded that the reactions of patients were different to the nurse and doctor, which resulted in differing depth of information gained to inform capacity assessment processes. Participants considered their close proximity to patients and the 24 hour exposure of the nursing role gave them opportunities to get to know patients and gave time for patients to feel more relaxed with them. Consequently, participants also indicated that their opinions and judgements of the capacity status of patients were generally accepted by doctors and used as the basis for medical assessments. Furthermore, participants indicated they had a continued role once referral to doctors had been made. They accompanied doctors to conduct medical assessment of patient capacity and reiterated information they had already provided thus trying to secure appropriate outcomes for patients. In this respect, participants described acting as advocates for patients.

4.4 Impact of Clinical Setting

Participants recognised that the nature of acute and critical care environments may exacerbate anxiety of ill patients. This, in conjunction with physical symptoms of acute and/or critical illness and interventions, may render patients having reduced capacity, no capacity or inability to demonstrate the presence of capacity:

*"Patients get overwhelmed by a hospital environment. This can be daunting for many patients, the amount of people who are there, the speed, the noise. I think it all plays a big part. They are scared at times, they see you rushing around and it all seems manic to them. Sometimes you can see they just want to get out of the environment as they feel they have lost control over what is happening to them. If I can see this happening I try to reassure them what is happening. Sometimes I leave them alone and observe from a distance to give them time to get used to it all. You have to take all of this into consideration when you are looking for ability to understand what is happening***"**

(F04).

The complexities of assessing capacity status in these contexts were exacerbated by the possibility of capacity fluctuating and the nature of capacity status may therefore be transitory. Participants described the potential for an ebb and flow of lucid moments and of capacity returning if physical symptoms were alleviated. The need for continual assessment of capacity was therefore considered imperative to assess the potential for fluctuations in understanding and awareness of patients. A capacity continuum was identified ranging from no capacity to full capacity with levels of capacity fluctuating at points between the two.

The challenging nature of acute and critical care environments combined with the unstable capacity and physical status of patients suggested that many patients may be vulnerable. Therefore, demonstrating a caring approach towards patients who were challenged by unfamiliar and frightening clinical environments was considered important.

4.5 Caring Role of the Nurse

There were several elements to the caring role of the nurse in this study. Participants articulated a strong professional responsibility to secure what they regarded as the best outcomes for patients during assessment processes. As they made referrals to doctors to continue and formalise assessment processes, participants described making attempts to safeguard the quality of these. They demonstrated awareness of their accountability when making decisions about patient capacity and expressed concerns regarding the difficulty in assessing capacity. They regarded this as clinically challenging due to the complexity of patients' physical symptoms, unstable clinical status and impact of clinical environment. They also alluded that capacity was difficult to assess:

> *"It is hard to assess capacity. You can't see it like a physical symptom, but you have to interpret the signs of it like how patients look, how they behave, the way they respond to you. This is such a grey area and is really hard to get right. It's a matter of interpretation. When you factor in the very ill patient there is little time for this but these patients may have capacity and will need to make decisions. We have responsibility to get this right because all patients need support due to being ill"* **(F11).**

Assessing and concluding that a patient lacked capacity was regarded as a significant responsibility, the implications of which were considerable for patients because they were potentially denied opportunities to make their own decisions. Hesitancy was expressed about doing this as it was regarded as eroding patients' autonomy. This was commonly described as "taking a part of the person away" and was potentially stigmatising. Participants regarded themselves as patient advocates and considered that assessing capacity accurately was an essential aspect of their advocacy role:

> *"There is a big stigma in saying that a patient is without capacity. If I am questioning capacity, I would prefer to say that they are not capable to decide for themselves, that they are not in the right place to make decisions like this. To be honest I am a little bit intimidated to say that a patient does not have capacity. If I do, I feel as though it's taking away such a big part of the person. I feel that being an advocate means that we have to assess properly, if not we take decisions away from a patient which is a really big thing. Making decisions on behalf of a patient is a big responsibility. We should not label a patient as being without capacity lightly. There in a danger in saying without capacity and also in not assessing regularly to see if they have regained any capacity"* **(F09).**

For patients with capacity, participants' advocacy role was linked to the need to inform, reassure and support patients and help them feel settled and comfortable in clinical environments and adequately supported to make appropriate decisions:

> *"Helping a patient to settle and reassuring them can go some way to calming them down. This gives the nurse a better chance of doing what is best for patients as you can sometimes see what they are normally like. I always go to my patients and ask is there anything that they don't understand especially when the doctors have spoken to them. They need nurses do to this as they feel more comfortable with us and we can support them to make decisions. I always try to talk to the patient as much as possible as soon as they come in. Sometimes we can overload patients with information and it's no wonder that they seem disorientated. They have the right to make decisions and to change their minds and I think we should be there for them, to make them feel comfortable and to advocate for them if needed. The nurse plays a very big role in advocacy for the patient"* **(Interview 4).**

Supporting the rights of patients in a multi-professional approach was considered a significant aspect of the role of participants who felt they were assertive in the need to

serve the best interests of patients. However, it was recognised that multi-professional decision making was the preferred way to meet the needs of patients. A team approach was considered effective for depth of assessment processes and sharing of information. This was regarded as primarily nurse-led with information provided to doctors during nurse-led referral processes.

In what they regarded as their central role in processes of assessment, participants indicated that they would like to have a framework to facilitate the assessment of patient capacity. The need to have "something that could be used quickly but not tick boxes" was suggested as was a "guide or something to support asking questions and having an outcome". Generally, a "framework" was suggested to support systematic assessment processes and a tool or guide which may assist in formalising nurse-led assessments of capacity. Participants recognised a need to document what they did to assess and record their conclusions about capacity status in patient records, thus leaving evidence trails and meeting legal and professional requirements.

5. Discussion

The grounded theory of Nurse Managed Patient Focussed Assessment and Care was developed from data provided by qualified nurses employed in acute and critical care settings in a district general hospital. This theory provides a framework for understanding how qualified nurses respond to adult patients in their care, are informed by influencing factors, conduct informal assessments of mental capacity and inform on-going assessment processes. This theory also highlights nurses' caring role in supporting autonomy and meeting the holistic needs of patients and further extends what is known about a key element of assessment processes in acute and critical care settings. The role of the nurse in assessing mental capacity are process which appear to be hidden and applied during day-to-day nursing activities. These processes may be regarded as having significance in supporting the decision making abilities of patients across acute and critical care settings.

A visual representation of the grounded theory of Nurse Managed Patient Focused Assessment and Care is illustrated in figures 1 and 2. Figure 1 represents the category "Factors Informing Nurse-Led Assessment" and summarises underpinning knowledge and specific areas of baseline information and clinical data to inform assessment of capacity status. In addition, the category, "Impact of Clinical Setting" is represented in the context of nursing assessment. The appearance of patients, their baseline observations and levels of distress/anxiety may be directly affected by physical and environmental factors.

Figure 2 explains processes of assessment and on-going care of patients. The category, "Nurse Led Assessment" explains depth of process for nurse specific perspective and intervention. The category, "Influence of the Role of Others" explains a multi-professional contribution and places nurses as co-ordinators and managers of ongoing assessment processes due to their proximity to patients and their ever-present status in clinical settings. The category, "The Caring Role of the Nurse" explains that assessing capacity is placed in the context of the provision of continuous person-centred which is supportive of the rights of patients.

Therefore figures 1 and 2, used together, represent the grounded theory of Nurse Managed Patient Focused Assessment and Care:

Figure 1 and Figure 2 here

Nurse managed patient focused assessment processes contain a number of complex elements. Central to the impact of clinical setting is that physical illness may have a significant impact upon the capacity status of patients (Raymont et al., 2004; Owen, 2009; Fassassi et al., 2009; Burton et al., 2012; Stevens, 2013). Participants in this study act on knowledge that patients may have a variety of healthcare needs of differing levels of acuity, complexity and severity, all of which may manifest in different ways. Additionally, the reactions of patients to admission to acute hospital environments may be unique and may impact upon the manner of their presentation. The capacity of patients may be hidden as a result and severe deterioration in the condition of patients is frequently preceded by changes of physiological parameters and accompanied by deterioration in awareness and lucidity (Hands et al., 2013). The mental capacity of patients may be compromised, but

processes for assessing this are inevitably influenced by clinical imperatives to stabilise and treat immediate healthcare needs. Therefore assessing capacity carries responsibility, presents the multi-professional team with several challenges in time pressured contexts (Hodgetts et al., 2002; Mohammed et al., 2009; Pearson, 2013).

The theory of Nurse Managed Patient Focused Assessment and Care suggests that several assessment techniques are employed which include the use of subjective criteria such as personal standards, definitions of "normal", and/or socially acceptable modes of behaviour and communicating. These inform decisions to proceed with assessing capacity in more depth. Existing research regarding the use of subjective data provides a somewhat mixed message (Eliot, 2010; Cork, 2014). Elements of this suggest that such data are valuable, can inform processes of assessment and can be relied upon in urgent and time limited clinical settings (Morrison & Symes, 2011). However, research also indicates that subjective data are unreliable, too individualistic and reliant on the knowledge and skills of each practitioner (Lynch et al., 2012). This study reveals opinions that the application of subjective data occurs rapidly and seemingly without much conscious thought. This results in descriptions of "gut feelings" about the presentation of patients which is articulated and labelled as "something not quite right". This supports evidence from other studies, so much so that participants in this study use similar language to that already reported in the expression of feelings of unease, concern and the articulation of gut feelings (Coiffi, 2000; Andrews & Waterman, 2005: Lyneham et al., 2008; Cork, 2014). Gut feelings have diagnostic value and have specificity when used in assessing levels of seriousness of symptoms of patients and can lead to in-depth assessments (Van den Bruel et al., 2012; Ingram, 2013).

Processes, knowledge, skills and techniques to assess mental capacity are consistent with those identified in literature as being effective in the assessment of the physiological status of patients (Higgins et al., 2008; Elliot, 2010; Perez & Folse, 2011; Morrison & Symes, 2011; Cork 2014). Including the assessment of contextual, psychosocial and emotional needs can bring together the concepts of mental capacity, wellbeing and physiological status. The techniques for assessing these can be combined to facilitate a more holistic approach to assessment. Emphasis on the potential vulnerability and dependence of acutely ill adult patients broadens the scope of what can be assessed which perhaps indicates the

assessment of mental capacity is not necessarily a lone process but one element in a dynamic and responsive holistic assessment process and for which a multi-professional approach is necessary.

The theory of Nurse managed Patient Focused Assessment and Care extends what is currently known about the acute and critical care nursing role in the assessment of mental capacity and illustrates what is a potentially "hidden process". The significance of informal nursing actions and processes applied during day-to-day nursing activities may be missed or not realised, in particular, the value of the physical and professional proximity of qualified nurses to patients (Josse-Eklund et al., 2014). The time limited nature of acute and critical care settings often means that information gathering is challenging and any information obtained is valuable. Therefore qualified nurses have knowledge about patients and their families in greater depth than any other professional group (Skar, 2009). This enables them to prioritise the needs of patients and function as reference points, sources of information and co-ordination for other professional groups (Ryan et al., 2012). This is key when assessing the mental capacity of patients in view of a central tenet of the Mental Capacity Act 2005 of assisting and supporting people to make their own decisions. The implications of concluding capacity is reduced or absent may be profound. Loss of autonomy, stigmatisation and receiving care and treatment without consent are recognised as potential implications of concluding that capacity is (Bates & Skickley, 2013; McKie & Naysmith, 2014; Jones, 2016). This assessment is therefore of fundamental importance, with qualified nurses key professionals in facilitating assessments that are supportive of the autonomy and rights of patients.

Acute and critically ill adult patients are placed at the centre of this study by participants who regard themselves as patient advocates. The theory of Nurse Managed Patient Focused Assessment and Care makes a contribution to knowledge in relation to the caring role of qualified nurses in acute and critical care settings. The theory highlights a professional drive to support and uphold the rights of patients and reveals empathetic approaches regarding the impact of illness and environment, recognising that patients may be confronted with their own mortality (Griffiths, 2015) This fuels a drive to ensure that the best outcomes are achieved and appropriate assessments are conducted, thus maximising decision making

abilities of patients and assisting them to gain a sense of control. This links to the professional responsibilities of nurses who are required to empower and protect the interests of patients in their care. (Hanks, 2010; Griffiths, 2015a; NMC, 2018). This also suggests an advocacy role that is wider than the traditional definition of speaking on behalf of patients (Seal, 2007; Dimond, 2015) and one that is linked to professional and legal requirements of the nursing role. Securing and maintaining the patient dignity and best outcomes for them should be a driving motivator to discharge professional accountability. In fast moving acute and critical care environments nurses have to balance the need to provide care in pressurised environments and also ensure compassion, dignity and respect for patients (Bridges, 2012; Lindwall & von Post, 2013). Therefore, the assessment of mental capacity has fundamental significance and is influential in the ways in which patients are regarded, cared for and managed in complex clinical settings.

6. Limitations

There are a number of limitations to this study. The findings of this study are based on descriptions, articulation and discussion of methods of assessing the mental capacity of adult patients and their on-going care and management. They constitute verbal accounts only and may not reflect the realities of the role and function of qualified nurses across acute and critical care settings. Caution must therefore be exercised when interpreting the study findings and/or the core category. Furthermore, one district general hospital was used from which 13 participants were recruited. This hospital provides a full range of acute, critical care and support services and may be regarded as representative of this type of facility serving an urban population. However, caution need to be exercised when applying the findings of this study to other hospitals of similar profile. In addition, it cannot be assumed that participants in this study are representative of other staff with similar profiles and from similar clinical settings in similar district general hospitals.

7. Conclusions

Nurse Managed Patient Focused Assessment and Care is an explanatory framework which has provided clarity in an area of nursing practice for which there is little existing evidence. The theory explains that qualified nurses assess the mental capacity of acutely and critically ill adult patients in some breadth and depth and this is a significant area of assessment

when facilitating patient autonomy and best interests. The theory offers a view that places nurses at the centre of a multi-professional team approach in the co-ordination of on-going cyclical assessment and care of patients.

Informal, sometimes instinctive, assessment processes are used, which lead to techniques in which the mental capacity and physical status of patients are combined and facilitates a holistic assessment approach. This appears to be regarded as an anticipated, clinically effective and time-efficient way of assessing the needs of adult patients in fast-moving clinical settings and suggests that assessing capacity status is not a separate process and should therefore be placed in the context of the individual presentation of each patient.

8. Relevance to Clinical Practice

The theory of Nurse Managed Patient Focused Assessment and Care, can assist the practice of acute and critical care in several ways. The assessment of mental capacity should be regarded as a fundamental aspect of the role of the qualified nurse. Multi-professional assessment of mental capacity should be conducted as part of a holistic assessment of the condition and needs of patients in acute and critical care environments. In this respect qualified nurses appear to manage and co-ordinate assessment of mental capacity and on-going patient care. This key role should be recognised across professional groups due to the significance of nurse initiated and led assessment processes and the value of the proximity of qualified nurses to patients and the depth of information that nurses have about patients and their families. Furthermore, the multi-professional team should strive to maximise the decision making abilities of acutely ill patients in time pressurised contexts. This places qualified nurses in prime positions to act as patient advocate and to provide care that is appropriate and patient focussed.

The education of qualified nurses may be informed by the findings of this study regarding the range of knowledge and skill required to conduct in-depth holistic assessments of adult patients across acute care settings, with particular focus on the legal and professional implications of the outcomes of mental capacity assessments. Themes such as autonomy, dignity, fluctuating capacity and the impact of physical illness are suggested. This also suggests that inter-professional programmes of education are indicated which may inform

different professional groups of the significance of a cohesive, cyclical approach to capacity assessment. **(7895 words)**

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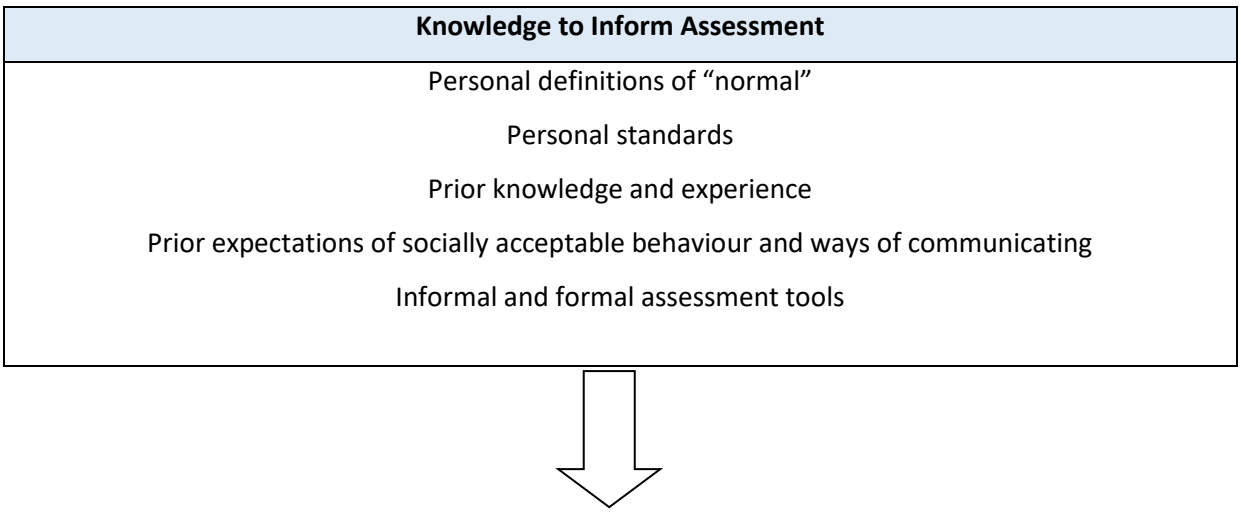
Figure 1: Nurse Managed Patient Focused Assessment and Care



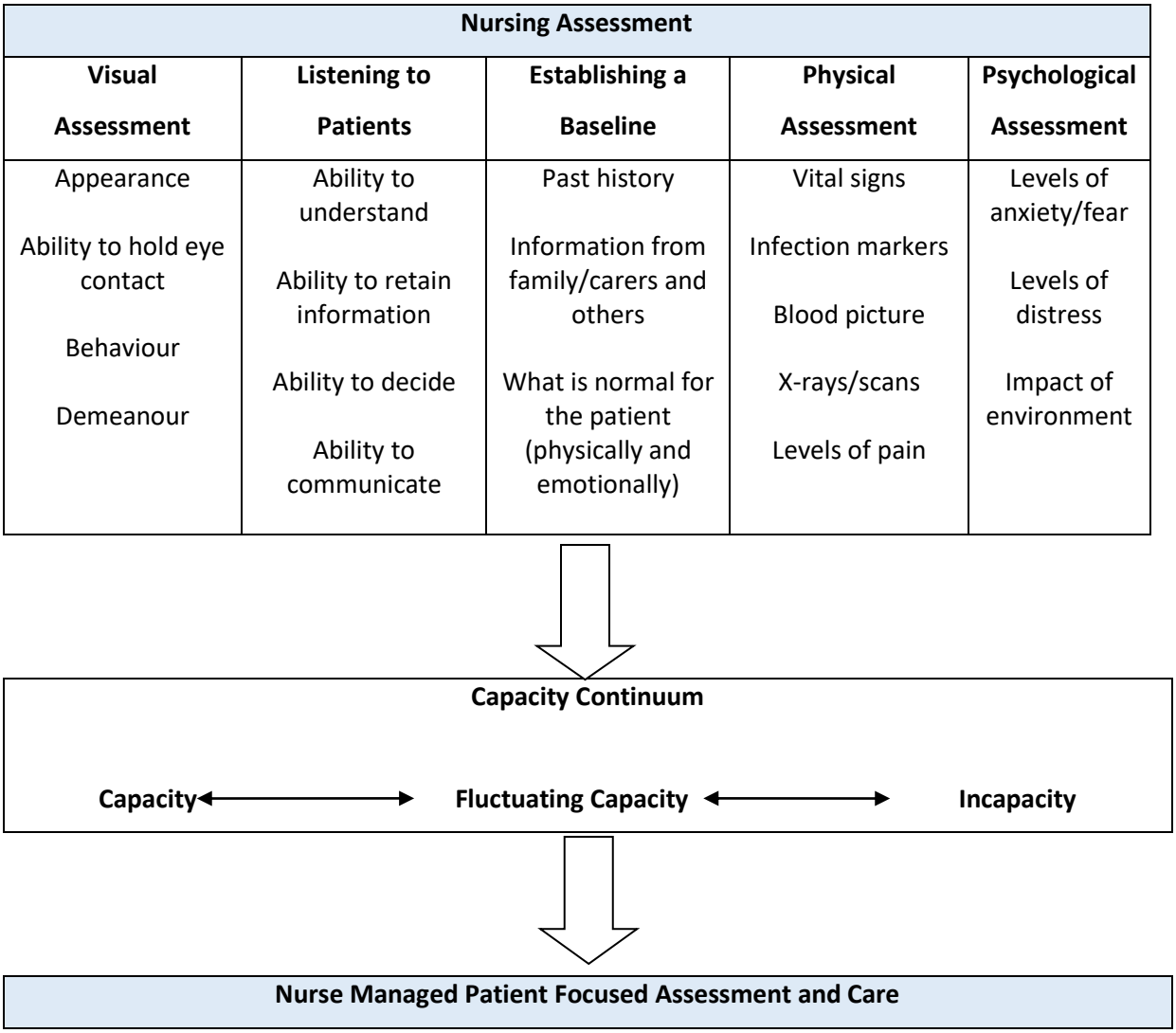
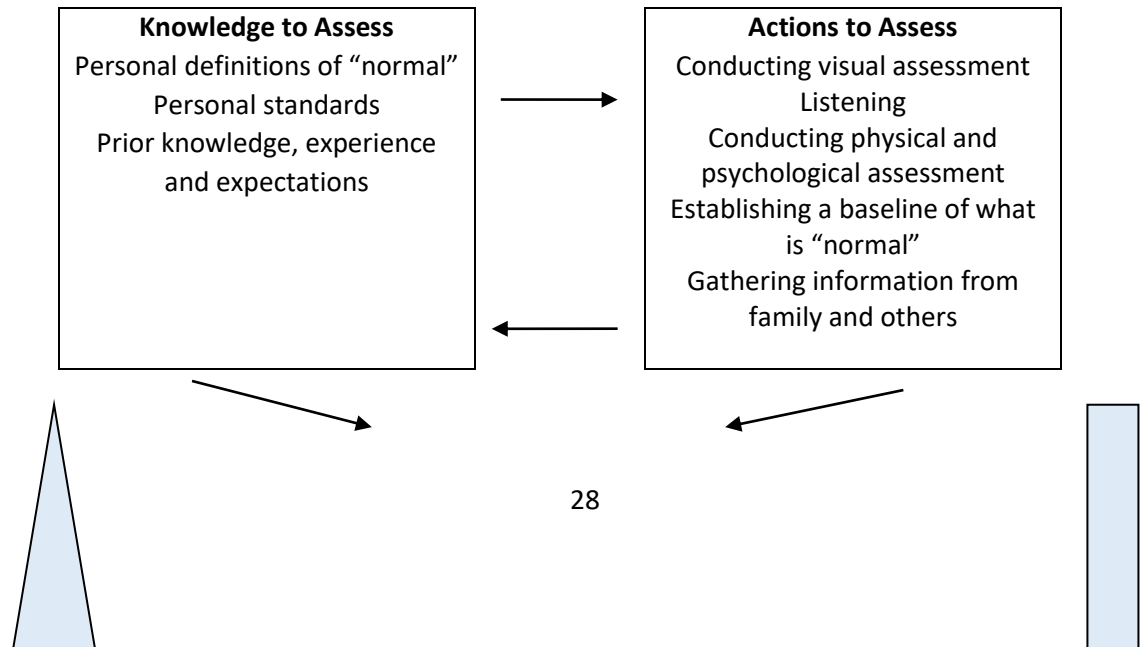
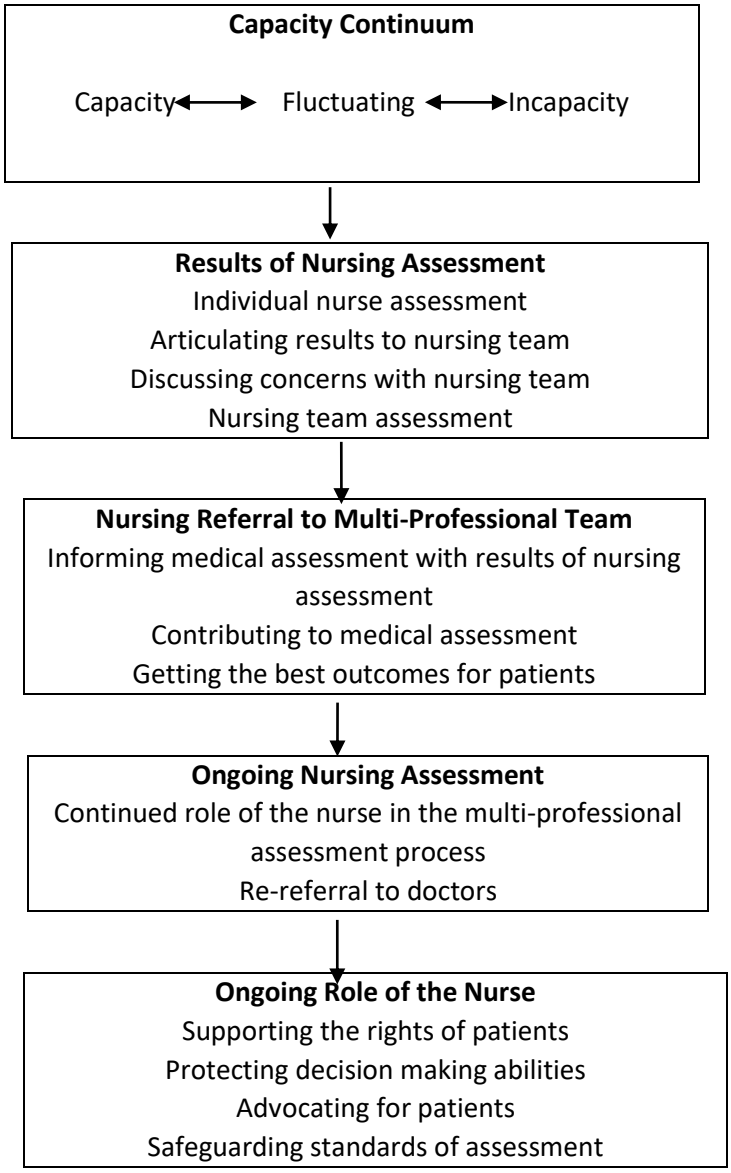


Figure 2: Nurse Managed Patient Focused Assessment and Care

The Assessment of Capacity Cycle




Capacity Continuum
Capacity
Fluctuating
Incapacity
Results of Nursing Assessment
Individual nurse assessment
Articulating results to nursing team
Discussing concerns with nursing team
Nursing team assessment
Nursing Referral to Multi-Professional Team
Informing medical assessment with results of nursing assessment
Contributing to medical assessment
Getting the best outcomes for patients
Ongoing Nursing Assessment
Continued role of the nurse in the multi-professional assessment process
Re-referral to doctors
Ongoing Role of the Nurse
Supporting the rights of patients
Protecting decision making abilities
Advocating for patients
Safeguarding standards of assessment